SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
Company Tracking Number:	*ALTLP-05*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Life*		
Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Filing at a Glance

Company: Amalgamated Life Insurance Company

Product Name: Group Life	SERFF Tr Num: AMAL-126774572	State: Arkansas
TOI: L04G Group Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 46529
Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium	Co Tr Num: ALTLP-05	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Claire Pizzuti	Disposition Date: 08/19/2010
	Date Submitted: 08/18/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Group Term Life Policy	Status of Filing in Domicile: Authorized
Project Number: ALTLP-05	Date Approved in Domicile: 08/03/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association, Other
Filing Status Changed: 08/19/2010	Explanation for Other Group Market Type: Unions
	State Status Changed: 08/19/2010
Deemer Date:	Created By: Claire Pizzuti
Submitted By: Claire Pizzuti	Corresponding Filing Tracking Number:

Filing Description:

The forms included in this filing are new and will not replace any other previously filed or approved forms.

Form ALTLP-AR-05, Group Term Insurance Policy provides term insurance protection to an individual eligible to be insured under the group policy. The policy provides for conversion upon termination. Form ALTLC-AR-05 is provided to the individual insured as evidence of coverage under the group policy.

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
Company Tracking Number:	*ALTLP-05*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Life*		
Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Forms ALLIDIEOI-AR-10, Evidence of Insurability, ALLIDIE-AR-10, Life/Disability Enrollment Form and ALLIDIA-AR-10, Group Policy Application, will be used to apply for coverage. These 3 application forms will also be used with LTD and STD forms that will be submitted at a later date.

The following optional benefit riders are available for use with this group life policy and any other that may be approved in the future. These riders may be used either at the time of issue or added on later.

Form ALTLADDRC-AR-05, Accidental Death & Dismemberment Rider, provides a benefit upon the accidental death or dismemberment of the insured.
Form ALTLADDRepRC-AR-05, AD&D Repatriation of Remains Benefit Rider provides reimbursement for covered expenses incurred to transport an insured's body to his or her country.
Form ALTLADDSBRC-AR-05, AD&D Seat Belt and Air Bag Benefit Rider, provides coverage upon death as a result of a motor vehicle accident while driving or riding as a passenger in an automobile.
Form ALTLCCRC-AR-05, Continuation of Coverage Rider, provides for continued coverage after the insured's eligibility ends under the group policy.
Form ALTLWPRC-AR-05 Waiver of Premium Rider, provides for a waiver of premium upon the disability of the insured.

Form ALTLRDBEC-AR-05, Reduction of Death Benefit Endorsement, provides for a reduction in benefit amount after the policy anniversary following an insured member's specific age.

Form ALTLABRC-AR-05, Accelerated Benefit Rider provides for the accelerated payment of a portion of the scheduled Certificate Death Benefit in effect upon diagnosis of a terminal condition. Only one accelerated benefit payment per covered person is allowed. There is no separate premium charge for this rider. There are no cash values associated with this rider.

The following forms are included for informational purposes only under the Supporting Documentation tab. They were previously approved for use on 11/20/09 under SERFF tracking number AMAL-126333212 with Living Benefit Rider ALTLLBRC-07:
Form AMADB-AD-PLUS-01-FW - Claim Form. Used at time of request for benefit under ALTLABRC-AR-05.
Form AMADBDIS-PLUS-01 - Disclosure form. Used at time of request for benefit under ALTLABRC-AR-05.
Form AMADBDIS2-PLUS-01 - Generic Illustration. Used at time of request for benefit under ALTLABRC-AR-05.

This product is intended to be marketed primarily to labor union groups but may also be marketed to employer groups and employee welfare trust funds. The product will be sold through Amalgamated Life Sales Executives and brokerage firms.

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
Company Tracking Number:	*ALTLP-05*		
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Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Bracketed text indicates variability dependent primarily upon the type of group to which the policy is issued and the benefits selected. When the variable is a numerical range within brackets, any number selected would be chosen from within the specified range.

The forms have been completed in John Doe fashion and are subject to minor modification in paper size and stock, ink, logo, border and adaptation to electronic printing.

Company and Contact

Filing Contact Information

Claire Pizzuti, Policy Form Compliance Manager	cpizzuti@amalgamatedlife.com
333 Westchester Avenue	914-367-5581 [Phone]
White Plains, NY 10604	914-367-4115 [FAX]

Filing Company Information

Amalgamated Life Insurance Company	CoCode: 60216	State of Domicile: New York
333 Westchester Ave.	Group Code:	Company Type:
White Plains, NY 10604	Group Name:	State ID Number:
(914) 367-5581 ext. [Phone]	FEIN Number: 13-5501223	

Filing Fees

Fee Required?	Yes
Fee Amount:	$600.00
Retaliatory?	No
Fee Explanation:	12 forms @$50 each
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Amalgamated Life Insurance Company	$600.00	08/18/2010	38853256

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
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Product Name:	*Group Life*		
Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/19/2010	08/19/2010

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
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Product Name:	*Group Life*		
Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Disposition

Disposition Date: 08/19/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
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Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Claim form, etc.		Yes
Form	Group Term Life Policy		Yes
Form	Group Term Life Insurance Certificate		Yes
Form	Accidental Death & Dismemberment Benefit Rider		Yes
Form	AD&D Seat Belt & Airbag Benefit Rider		Yes
Form	AD&D Repatriation of Remains Benefit Rider		Yes
Form	Continuation of Coverage Benefit Rider		Yes
Form	Waiver of Premium Benefit Rider		Yes
Form	Reduction of Death Benefit Endorsement		Yes
Form	Accelerated Benefit Rider		Yes
Form	Group Policy Application		Yes
Form	Life/Disability Enrollment Application		Yes
Form	Evidence of Insurabilty Form		Yes

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
Company Tracking Number:	*ALTLP-05*		
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Product Name:	*Group Life*		
Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Form Schedule

Lead Form Number: ALTLP-05

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ALTLP-AR-05	Policy/Contract/Fraternal Certificate	Group Term Life Policy	Initial		46.400	Group Term Policy all pages ALTLP-AR-05.pdf
	ALTLC-AR-05	Certificate	Group Term Life Insurance Certificate	Initial		48.300	Group Term Certificate all pages ALTLC-AR-05.pdf
	ALTLADDRC-AR-05	Certificate Amendment, Insert Page, Endorsement or Rider	Accidental Death & Dismemberment Benefit Rider	Initial		55.000	ADD Rider ALTLADDRC-AR-05.pdf
	ALTLADDSBRC-AR-05	Certificate Amendment, Insert Page, Endorsement or Rider	AD&D Seat Belt & Airbag Benefit Rider	Initial		48.400	ADD Seat Belt Rider ALTLADDSBRC-AR-05.pdf
	ALTLADDRepRC-AR-05	Certificate Amendment, Insert Page, Endorsement or Rider	AD&D Repatriation of Remains Benefit Rider	Initial		46.100	ADD Repatriation Benefit Rider ALTLADDRepRC-AR-05.pdf
	ALTLCCRC-AR-05	Certificate Amendment	Continuation of Coverage Benefit	Initial		49.200	continuation of Coverage

	t, Insert Page, Endorsement or Rider	Rider				Rider ALTLCCRC-AR-05.pdf
ALTLWPRC-AR-05	Certificate Amendment, Insert Page, Endorsement or Rider	Waiver of Premium Benefit Rider	Initial		45.500	Waiver of Premium Rider ALTLWPRC-AR-05.pdf
ALTLRDBEC-AR-05	Certificate Amendment, Insert Page, Endorsement or Rider	Reduction of Death Benefit Endorsement	Initial		47.700	Reduction of Death Benefit End ALTLRDBEC-AR-05.pdf
ALTLABRC-AR-05	Certificate Amendment, Insert Page, Endorsement or Rider	Accelerated Benefit Rider	Initial		46.400	Accelerated Benefit Rider ALTLABRC-AR-05.pdf
ALLIDIA-AR-10	Application/ Enrollment Form	Group Policy Application	Initial		45.800	ALLIDIA-AR-10 final.pdf
ALLIDIE-AR-10	Application/ Enrollment Form	Life/Disability Enrollment Application	Initial		47.400	ALLIDIE-AR-10 final.pdf
ALLIDIEOI-AR-10	Application/ Enrollment Form	Evidence of Insurabilty Form	Initial		45.200	ALLIDIEOI-AR-10 final.pdf

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, New York 10604

GROUP TERM LIFE INSURANCE

GROUP POLICY NUMBER [12345]

Policyholder's Name	**[XYZ Corporation or Trustee]**
Policyholder's Address	**[123 Main Street, Blue Bell, AR]**
Effective Date of Issue of Group Policy	**[June 1, 2006]**
[Participant Organization's Name & Identification Number	**[ABC Inc] [Id Number]]**
[Effective Date of Participation	**[MM/DD/YY]]**
Anniversary Date	**[July[1], of each year beginning [2006]**
Premium Due Date	**[Monthly], [on the first day of each policy month]**

CONSIDERATION AND INSURING CLAUSE

In consideration of the representations in the Policy application (copy attached and made part hereof); and in the individual Enrollment Form and upon payment of the applicable premium for each Insured as provided and subject to all the exceptions, limitations, reductions and other terms of the Policy; the Company (Amalgamated Life Insurance Company) hereby agrees with the Policyholder:

TO PROVIDE Life Insurance & related benefits to "Eligible Persons" who are enrolled according to the terms of this Policy. Benefits shall be provided as described in the Schedule of Benefits and in other parts of the body of this Policy.

The Policy is issued for delivery in Arkansas.

_____

President

Group Term Life Insurance Policy

Non Participating

POLICY SCHEDULE

GROUP POLICY NUMBER [12345]

Policyholder's Name **[XYZ Corporation or Trustee]**

Date Group Policy Issued **[June 1, 2006]**

[Participant Organization's Name & Identification Number **[ABC Inc]** **[Id Number]]**

[Effective Date of Participation **[MM/DD/YY]]**

BENEFIT SCHEDULE

[As shown in the Schedule of Insurance included in the Certificate of Insurance]

[Eligible Classes **[Member/Employee] of [Policyholder /Participant Organization]**

[Class(es) of Insureds **[Class 3-A]]**

[Eligible Person **[Actively at Work [for [30] Hours/Week] [Others – e.g. Board of Directors/ Retired Member/Spouse/Dependent]]**

[Eligibility Waiting Period **[30][Days/Months]/[Probationary Period]]**

[Plan of Insurance **C]**

[Basic/Supplemental/Optional] Life Insurance Benefit – Active Member, Retired Member, Spouse, Dependent Child]
[

	[Basic]	[Supplemental]	[Optional]
Active Member	**[$25,000 to 100,000]**	**[$10,000]**	**[$10,000]**
Retired Member	**[$20,000 to 50,000]**	**[$10,000]**	**[$10,000]**
Spouse	**[$10,000 to 50,000]**	**[$5,000]**	**[$5,000]**
Dependent Child	**[$2,000 to 10,000]**	**[$2,000]**	**[$1000]**

]

[Accidental Death & Dismemberment (AD&D)/ Repatriation of Remains/Seat Belt Benefit]
[

	[Active]	[Retired]	[Spouse]
AD&D	**[$25,000 to 100,000]**	**[$10,000]**	**[$10,000]**
Repatriation of Remains	**[$20,000 to 50,000]**	**[$10,000]**	**[$10,000]**
Seat Belt	**[$10,000 to 50,000]**	**[$5,000]**	**[$5,000]**

]

[Age reduction schedule applies.]]

POLICY SCHEDULE (Continued from previous page)

PREMIUM SCHEDULE

[[Premium Payable [Weekly/Monthly/Quarterly/Annually]]
[Premium Rate Guaranteed for: [2] [Years]] Subject to Rate Revisions At Any Time Upon Change in Demographics of the Class of Insureds by More Than [10%]]

[Life Insurance:

Age	[Premium Per $1,000 Per Month]								
	[Active]			[Retired]			[Spouse]		
	[Basic]	[Supple-mental]	[Optio-nal]	[Basic]	[Supple-mental]	[Optional]	[Basic]	[Supple-mental]	[Optional]
[LT 20]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]
[21 -25]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]
[26-30]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]
[31-35]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]
[36-40]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]
[41-45]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]
[46-50]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]
[51-55]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]
…….	…….	…….	…….	…….	…….	…….	……	…….	…….

Dependent Child **[$0.25/$1,000] Per month]**

[AD&D / Repatriation of Remains/ Seat Belt Benefit:

Premium/$1,000/Month **[$0.15] for Active**
[$0.20] Spouse
[$0.20] Child]

[Accelerated Benefit/ Critical Illness Benefit:

Premium/$1,000/Month **[$0.25] for Active**
[$0.30] Spouse
[$0.20] Child]

[Waiver of Premium Benefit:

Premium/$1,000/Month **[$0.10] for Active**
[$0.15] Spouse
[$0.20] Child]

POLICY SCHEDULE (Continued from previous page)

[Continuation of Coverage Benefit:

Premium/$1,000/Month	**[$0.45] for Active**
	[$0.65] Spouse
	[$0.20] Child]

[Life Insurance Portability Benefit:

Premium/$1,000/Month	**[$0.45] for Active**
	[$0.65] Spouse
	[$0.20] Child]

[[Retiree], [Dependent], [Supplemental] Life Insurances], [Waiver of Premium] is/are not Provided by this Policy.]

TABLE OF CONTENTS

Table of Contents of Certificate of Insurance (COI)
Form No. ALTLC-AR-05
(Incorporated Into this Policy Form # ALTLP-AR-05)

POLICYHOLDER

A Policyholder means [a labor union/ a health & welfare trust fund/a Trade Association/ a Multiple Employer Trust/ an Employer or any other entity recognized legally as a Group] to which the Group Policy is issued.

[An employer//labor union may be included as a Participant Employer/organization if the Policyholder and the Company so agree. The Company will keep a list of accepted Participant Employers/organizations; and the effective dates of coverage for each.

The Policyholder may act for or on behalf of all Participant Employers/organizations in all matters of the policy. The following will be binding on all Participant Employers:

- all agreements between the Company and the Policyholder;
- all notices from the Company to the Policyholder; and
- all notices from the Policyholder to the Company.

An employee of a Participant Employer/organization will be deemed to be an employee of the Policyholder for insurance purposes.]

Coverage for a Participant Employer/organization will terminate on the first to occur of:

- the date his premium is due, but not paid; or
- the date on which the Policyholder wants the employer to be removed from the policy. Such date must be stated in written notice to the Company; and it must be after the date of the notice.

INCORPORATION OF CERTIFICATE PROVISION

Incorporation of the Certificate of Insurance

The Certificate of Insurance along with any Endorsement and Rider Forms attached to it is hereby incorporated in and made part of this policy.

The terms found in the Certificate of Insurance will control:

- the benefit plan provisions;
- the eligibility and effective date of insurance rules;
- the termination of insurance rules;
- exclusions; and
- other general policy provisions pertaining to state insurance law requirements.

INCORPORATION OF CERTIFICATE PROVISION (continued)

The following table sets forth the list of current Certificate, and any Endorsements & Riders attached to the Certificate, all of which are made part of this Group Policy.

Form	Form Number	Effective Date

ENDORSEMENT AND RIDER FORMS MADE PART OF THIS GROUP POLICY

The following index sets forth the list of Endorsements and Rider Forms attached to this Group Policy and made part of this Group Policy.

Form	Form Number	Effective Date

POLICY SCHEDULE

Policy Schedule
The Benefit Schedule in the Policy Schedule is as shown in Schedule of Insurance of the Certificate of Insurance provided to the certificate holder. A generalized benefit schedule is included in the Policy Schedule on page 2-A of this policy.

The Schedule of Insurance will control the:
- benefit amounts and maximum limits;
- eligibility and effective date rules; and
- other schedule amounts and limits,

which apply to the insured members of the Policyholder.

PREMIUMS

Initial Premium Rates
We have set the initial monthly premium rates that apply to the insurance provided by this policy. Those rates are shown in a notice given to the Policyholder with or prior to delivery of this policy. The initial premium rates are included in the Policy Schedule on page 2-A of this policy.

[The initial monthly premium rates may be converted as follows:

To Convert Rates to:	Use a Conversion Factor of:
annual rates:	11.8227
semi-annual rates:	5.9557
quarterly rates:	2.9852

]

Change in Premium Rates
Initial [Monthly] Premium rates are guaranteed for [12] months.

Subject to the Rate Guarantee period shown above, the Company has the right to change premium rates on any premium due date if:
- written notice is delivered to the Policyholder's last address on record; and
- the change is effective at least [31/45] days after the date of notice.

The rate guarantee supersedes only those provisions appearing elsewhere in this policy which give the Company the right to change the premium rates. However, the Company may change the premium rates during the Rate Guarantee period:
- if there is a change in the policy; and or if there is a [10%] increase or decrease in the number of insured employees; or
- if the Policyholder adds or deletes a subsidiary and or an affiliated business entity.

The Company may also change the premium rates during the guarantee period if there has been a material misstatement in the reported experience during the pre-sale process. The Rate Guarantee in no way affects, amends or supersedes any other provision in this policy.

The company may, upon 30 days advance notice to the Policyholder, set new premium rates to become effective on or at any time after the first anniversary.

Calculations and Adjustments
Premiums may be calculated by multiplying the rate times the applicable amount of insurance coverage.

If any insurance is added, increased or becomes effective after the policy is in force, the premium charges will begin:

- the day the coverage is effective, if it is also the first day of a policy month; or if not
- the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month.

Premiums may be calculated by any other method which both the Company and the Policyholder agree to.

Premium Payments

Premium payments are due and payable in full to a place designated by the Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of the Company.

Payment of premiums for a period before it is due will not guarantee the insurance for that period.

[Experience Rating Refund

If the policy is experience rated, any credit amount due the Policyholder will be allowed him at the end of every [2] Policy Years and, at the Policyholder's request, will be:

- paid to him in cash;
- used to reduce his premiums; or
- used to provide additional insurance for Covered Persons.

Any credit amount shall be determined by the rating methodology used by the Company.]

POLICY PROVISIONS

Entire Contract
The contract between the Company and the Policyholder consists of:

- the Policy;
- the Certificate of Insurance incorporated into the Policy;
- the Application of the Policyholder, a copy of which is attached to and made a part of the policy when issued; and
- [the Enrollment form and the Eligibility of Insurance form, if any, of each insured person (copy attached).]

All statements made by the Policyholder, Participant Employers, and persons insured under the policy are true and complete to the best of the knowledge and belief of the person(s) making them. No statement will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his beneficiary.

Right to Examine Policy
The Policy may be returned within 31 days after receipt if the Policyholder is not satisfied for any reasons; any premium paid will then be refunded.

Incontestability
Except for non-payment of premium, the insurance provided by the policy cannot be contested after a period of 2 years from the date of issue of such insurance.

Change in The Policy
The Company may not make any change unless approved in writing by the President; or a Vice President; or an Assistant Vice President; of the Company. No other person may change or waive any part of the policy. Any approved change shall be added to the policy in writing.

The policy may be changed, as indicated above, at any time. The consent of any insured individual is not required.

If any change to state or federal law, including but not limited to the Federal Social Security Act, affects the Company's liability under the policy, the Company may change the policy, the premiums or both. Such change:

- will be effective as of the date of the change to the state or federal law;
- will not be made until the Company gives the Policyholder 31 days notice.

Right to Amend
Notwithstanding the above, after the policy has been in force for 12 months, the Company may change any or all of the provisions of this contract by notifying the Policyholder. The Company must give the Policyholder at least 31 days advance written notice of any change.

Grace Period
A grace period of [31] days will be granted for the payment of each premium after the first. If premium is not paid in the grace period the policy will cease at the end of that period. The policy, on any class of insured individuals, will end before that date if you give us written notice in advance. When the policy ceases you will be liable to us for all unpaid premiums, including a pro-rata premium for any time this policy or a class of insured individuals was in force during the grace period

Termination of Policy
Except as set forth in the Grace Period provision, this policy will cease on default of payment of premium.

The Company may also terminate the policy, or any class of insured individuals on occurrence of the following events by giving the Policyholder [31/45/60] days written notice:

- The Policyholder fails to furnish any information which the Company may reasonably require;
- The Policyholder fails to perform any of his other obligations pertaining to this policy;
- Less than 100% of the persons eligible for coverage on a Non-contributory Basis are insured; or Less than [75%] of the persons eligible for coverage on a Contributory Basis are insured.
- Fewer than [10] persons are insured.
- With respect to any insured dependents:
  (a) If they are married, or
  (b) They have reached the age limit.

In addition, the Company may terminate this policy on any premium due date after the policy has been in force for 12 months.

Certificate
The Company will give the Policyholder [or Participant Employer] individual Certificate of Insurance for delivery to each insured individual. The certificate is part of the policy, and will explain the important features of the policy.

Data To Be Furnished
Insurance records will be kept to show, as to each person insured, all the data we need to administer this policy. Such records will be set up and kept by us or, if you and we so agree, by you. You will furnish us at our request, the data we need to administer the coverages and determine the premiums under this policy. If we keep the records referred to above, such data will include all the information that is required to keep those records. The data is to be furnished: 1) on our forms; or 2) on forms approved by us.

Clerical errors or delays in changing our records will not deprive or give a person insurance under this policy. If a person's insurance ends but the fact is not recorded, that insurance will not continue beyond the date it would have ended in accord with "Individual Terminations".

We will have access at reasonable times to inspect all of your records which pertain to this policy.

Trustee Policyholder
If you are a Trustee(s):

1. We are entitled to rely on the signature of one Trustee as authorized by all Trustees, provided to us in writing, in all matters concerning the policy, and
2. This policy is not subject to the terms of any trust agreement.

Time Period
All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

Jurisdiction
The laws of the state of Arkansas govern this Policy.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, New York 10604

GROUP TERM LIFE INSURANCE

CERTIFICATE OF INSURANCE

Effective Date of Certificate	**[MM/DD/YY]**
Certificate Holder's Name	**[John Doe]**
[[Group Policyholder's Name	**[XYZ Corporation or Trustee]]**
[Group Policy Number	**[12345]]**
[Group Policyholder's Address	**[123 Main Street, Blue Bell, AR]]**
[Effective Date of Group Policy	**[MM/DD/YY]]**
[Effective Date of Participation of Participant Organization	**[MM/DD/YY]]**
[Participant Organization's Name & Identification Number	**[ABC Inc] [Id Number]]**

This is to certify that, subject to the terms of the Group Policy under which this Certificate is issued, you are insured for the benefits as shown in the Schedule of Insurance and described in this Certificate.

Insurance takes effect only if you are eligible for it[, you elect it and you make contribution for it as required].

[This certificate takes the place of any prior one issued to you by us covering the insurance.] It is not an insurance contract. The group insurance contract is held by the Group Policyholder. You may request to inspect it at the Policyholder's office during usual business hours.

Amalgamated Life Insurance Company certifies that it has issued Group Policy Number [12345] and that the person named in this Certificate, and whose premium is paid, is insured for the benefits described, subject to the terms and conditions of the Group Policy. This Certificate provides valuable information about your benefit plan under the Group Policy.

President

Read Your Certificate Carefully

SCHEDULE OF INSURANCE

Effective Date of Certificate **[MM/DD/YY]**

Certificate Number **[12345-00123]**

Certificate Holder's Name **[John Doe]**

[Group Policyholder's Name and Number **[XYZ Corporation or Trustee][12345]]**

[Participant Organization's Name & Identification Number **[ABC Inc]** **[Id Number]]**

This plan of Group Term Life Insurance provides You and/or your spouse and dependents benefits upon your death and/or death of your spouse and dependents and/or upon the occurrence of other contingencies as described in this Certificate.

[You [must/do not] contribute towards the plan's cost.]

BENEFITS

[Eligible Classes **[Member/Employee] of [Policyholder /Participant Organization]**

[Class(es) of Insureds **[Class 3-A]]**

[Eligible Person **[Actively at Work [for [30] Hours/Week] [Others – e.g. Board of Directors/Retired Member/Spouse/Dependent Child]]**

[Eligibility Waiting Period **[30][Days/Months]/[Probationary Period]]**

[Plan of Insurance **C]**

[Basic/Supplemental/Optional] Life Insurance Benefit – Active Member, Retired Member, Spouse, Dependent Child]
[

	[Basic]	[Supplemental]	[Optional]
Active Member	**[$25,000 to 100,000]**	**[$10,000]**	**[$10,000]**
Retired Member	**[$20,000 to 50,000]**	**[$10,000]**	**[$10,000]**
Spouse	**[$10,000 to 50,000]**	**[$5,000]**	**[$5,000]**
Dependent Child	**[$2,000 to 10,000]**	**[$2,000]**	**[$1000]**

]

SCHEDULE OF INSURANCE (Continued from previous page)

[Accidental Death & Dismemberment (AD&D)/ Repatriation of Remains/Seat Belt Benefit]
[

	[Active]	[Retired]	[Spouse]
AD&D	**[$25,000 to 100,000]**	**[$10,000]**	**[$10,000]**
Repatriation of Remains	**[$20,000 to 50,000]**	**[$10,000]**	**[$10,000]**
Seat Belt	**[$10,000 to 50,000]**	**[$5,000]**	**[$5,000]**

]
[Age reduction schedule applies.]

[PREMIUM SCHEDULE

[[Premium Payable [Weekly/Monthly/Quarterly/Annually]]

[Premium Rate Guaranteed for: [2] [Years]] Subject to Rate Revisions At Any Time Upon Change in Demographics of the Class of Insureds by More Than [10%]]

[Life Insurance:

Age	[Premium Per $1,000 Per Month]								
	[Active]			[Retired]			[Spouse]		
	[Basic]	[Supple-mental]	[Optio-nal]	[Basic]	[Supple-mental]	[Optio-nal]	[Basic]	[Supple-mental]	[Optional]
[LT 20]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]	[$1.60]
[21 -25]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]	[$1.80]
[26-30]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]	[$1.90]
[31-35]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]	[$1.95]
[36-40]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]	[$2.10]
[41-45]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]	[$2.20]
[46-50]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]	[$2.40]
[51-55]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]	[$2.80]
…….	…….	…….	…….	…….	…….	…….	……	…….	…….

Dependent Child [$0.25/$1,000] Per month]

[AD&D / Repatriation of Remains/ Seat Belt Benefit:
Premium/$1,000/Month [$0.15] for Active
[$0.20] Spouse
[$0.20] Child]

[Accelerated Benefit/ Critical Illness Benefit:
Premium/$1,000/Month [$0.25] for Active
[$0.30] Spouse
[$0.20] Child]

SCHEDULE OF INSURANCE (Continued from previous page)

[Waiver of Premium Benefit:

Premium/$1,000/Month	**[$0.10] for Active**
	[$0.15] Spouse
	[$0.20] Child]

[Continuation of Coverage Benefit:

Premium/$1,000/Month	**[$0.45] for Active**
	[$0.65] Spouse]
	[$0.20] Child]

[Life Insurance Portability Benefit:

Premium/$1,000/Month	**[$0.45] for Active**
	[$0.65] Spouse]]
	[$0.20] Child]]

[[Retiree], [Dependent], [Supplemental] Life Insurances], [Waiver of Premium] is/are not Provided by this Policy.]

TABLE OF CONTENTS

DEFINITIONS

"We", "Us", "Our", "Company", "Life Insurance Company" means Amalgamated Life Insurance Company. Our Home Office Address is 333 Westchester Avenue, White Plains, NY 10604.

"You", "Your" means the Certificate Holder shown on Page 1.

"Individual", "Insured", "Insured Person" means the insured employee, retiree, spouse or dependent child.

"Certificate holder" means the insured employee or retiree.

"Policy", "Group Policy" means Group Policy issued to the Group Policyholder shown on page 1.

"Policyholder", "Group Policyholder" means the Group Policyholder to shown on page 1.

"Salary" means regular pay, not counting commissions, bonuses, overtime pay, or any other pay or fringe benefits.

"Eligible Employee" means a

[A. "Non-Union" Employee is an employee performing work for the Policyholder provided that:
1. the Policyholder's regular employment records indicate that the employee worked for at least [#] of hours/weeks/days in at least two out of the three months preceding the date of death; and
2. an employee for whom the Policyholder is withholding income taxes and paying unemployment insurance benefit premiums.]

[B. "Union": Employee is an employee performing work covered by the collective bargaining agreement, provided that:
1. the Employer is obligated to make contributions to the Fund for the purposes of obtaining Fund benefits for the employee;
2. the employee meets the Fund's criteria for eligibility for Fund benefits;
3. the Employer's regular employment records indicate that the employee worked in Covered Employment for at least #of hours/days/weeks per month in at least two out of the three months preceding the date of death; and
4. the Employer is withholding income taxes and paying for unemployment insurance benefits for the Employee.]

"Actively at Work" means the Individual is performing the regular duties of employment on that day either at the Employer's place of business or at some location to which the Employee is required to travel for the Employer's business. Actively at Work includes each day of a regular paid vacation and each regular non-work day if the Employee was Actively at Work on the last preceding regular work day.

"Total Disability", "Totally Disabled" means the incapacity of the Insured resulting from injury or disease, to engage in any occupation for remuneration or profit.

["Retiree" means an Individual who is eligible to receive a pension, worked for a contributing employer and meets the employer's criteria for eligibility.]

["Eligible Dependents" means (1) the lawful spouse of an insured; and (2) the unmarried child of the employee if the child is under (19) years of age; and (3) the unmarried child of an employee if the child is under (23) years of age and is enrolled as a full-time student.

["Spouse" includes Domestic Partners]

"Child" means a child of blood, marriage or named in a court order duly entered who is over 14 days old and financially dependent on the employee for support.

"Financially Dependent" means that the employee is furnishing over one-half of the dependent's total support as determined under the federal income tax laws and regulations.

"Full-time Student" means a student who is normally in daytime attendance without compensation at an educational institution not less than 12 hours per week or is otherwise a certified full-time degree candidate at an accredited college or university.

"Educational Institution" means an institution that maintains a regular faculty and curriculum and normally has a regular organized body of students in attendance where the educational activities are conducted.

ELIGIBILITY

I. APPLICABLE TO INDIVIDUALS

A. Subject to B., below

Each Individual, who is eligible for insurance under this plan on the date this policy becomes effective with respect to the class(es) of which he or she is a member, will be eligible on that date for the coverages in the policy's plan of insurance for such class(es).

Each other Individual will be so eligible on the day after the date he or she completes [one month] of continuous service in an eligible class.

B. If an individual is not at active work on the day he or she would normally become eligible, he or she will be eligible on the day that person resumes active work.

ELIGIBLE CLASSES

CLASS	DESCRIPTIONS

[As established by the Group Policyholder based on such conditions as compensation, hours of work, occupational duties, geographic situs, affiliation or membership in a labor union etc]

If the amount of any insurance under this policy is contingent upon the classification of an individual, and if at any time the individual's classification warrants an amount of insurance greater or less than that for which he is then insured, the amount of his insurance shall be increased or reduced to that warranted by his new classification on [_____] the date of change in the individual's classification, provided, however, that in any instance in which the individual is not actively at work on the date his insurance would otherwise be increased, the effective date of the increase in the individual's insurance shall be deferred until his return to active work.

For the purposes of this policy, a retroactive change in an Individual's rate of earnings shall be deemed to be effective on the day the change was actually determined.

EFFECTIVE DATES OF INSURANCE

[APPLICABLE TO INDIVIDUALS FOR WHOM CONTRIBUTIONS ARE REQUIRED.

If an Individual enrolls for his or her insurance on or before the day he or she becomes eligible, such person will be insured on the day he or she becomes eligible.

If an Individual enrolls for his or her insurance within 31 days after the day he or she becomes eligible, such person will be insured on the day he or she enrolls.

If an Individual enrolls more than 31 days after the day he or she becomes eligible, such person will not be insured until he or she satisfies Us of his or her good health. Such person may be asked to have a health examination at his or her own expense.

If an Individual is not at active work on the day his or her insurance would normally begin, that person will become insured on the day he or she resumes active work.]

[APPLICABLE TO DEPENDENTS

If a dependent is eligible for coverage under this policy as an Individual, he or she will not be so eligible as a dependent. If an Individual and his or her spouse are both insured under this policy as employees, their children may only be enrolled as dependents of one of the insured parents. Eligible children include the natural children and legally adopted children of the insured applicant.

If an Individual has dependents who are enrolled more than 31 days after they become eligible, such persons will not be insured until they satisfy Us of their good health. Each dependent may be asked to have a health examination at the Individual's expense.

In any other case, dependents will be insured:

(a) on the day they become eligible, if the Individual enrolls for their insurance on or before the day they become eligible.

(b) on the day the Individual enrolls them, if he or she enrolls for dependents' insurance within 31 days after the day they become eligible.

Except for a child at birth, if a dependent is confined to a hospital or other institution covered under the policyholder's plan on the day such person's insurance would normally begin, he or she will be insured on discharge.

An Individual's dependents will not be insured before the day his or her insurance begins.]

[APPLICABLE TO INDIVIDUALS FOR WHOM CONTRIBUTIONS ARE NOT REQUIRED.

Such Individual will be insured on the day he or she becomes eligible.]

INDIVIDUAL TERMINATIONS

Subject to any extension of coverage benefit, the insurance under this policy for an Individual ends when the first of the following events occurs:

(1) this policy ceases.

(2) the termination of the classes under which the Individual is a member.

(3) premium payments for the insurance of the Individual cease.

(4) the last day of the month in which the Individual's employment in the eligible class under this policy ends. His or her employment will be deemed to end when he or she stops active work[, except that, in the event of a temporary lay-off or leave of absence, the insurance will continue but not beyond 31 days in which the lay-off or leave of absence begins.]

(5) if the Employee is in active service in the armed forces of a country at war, declared or not, his or her insurance will stop.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract is made up of the policy, the application for the policy, the certificate of insurance, any enrollment form and eligibility of insurance form completed by you or any insured individual, copies of all of which are attached. Your or an insured's statements will be deemed representations and not warranties. No statement made by you or an insured shall be used in any contest of this insurance unless it is in writing signed by such person and a copy given to such person or his or her beneficiary.

GRACE PERIOD

A grace period of [31] days will be granted for the payment of each premium after the first. If premium is not paid in the grace period the certificate will cease at the end of that period. The certificate will end before that date if You give Us written notice in advance. When the certificate ceases You will be liable to Us for all unpaid premiums, including a pro-rata premium.

INCONTESTABILITY

This certificate will not be contested after it has been in force for two years from its Certificate effective date, except for the failure to pay premiums.

A statement made by an insured as to his or her insurability may be used to contest the validity of the insurance with respect to which the statement was made, if: 1) the statement is in writing and is signed by the insured; and 2) a copy of such statement is or has been furnished to the insured or the insured's beneficiary. Such statement may not be used to contest the validity of such insurance after it has been in force prior to the contest for two years during the lifetime of the insured.

BENEFICIARY

The beneficiary of the individual's insurance for loss of life, including those with respect to accidental death, if any, will be the person(s) named by the insured as shown on the records kept by the Company on this policy. The insured may change such beneficiary at any time by giving written notice to us. Such change will take effect on the date the notice is signed, without prejudice to us, because of prior payment made in good faith based on our records. If there is no named beneficiary, as to any part of the benefits, living at the date of death of the insured, that part will be paid in a lump sum to the Executors or Administrators of the insured's estate, or at our option, to the survivors in the first surviving class of those that follow:

a. spouse b. children, equally c. parents, equally d. brothers and sisters, equally

If no beneficiary survives, benefits will be paid in a lump sum to the insured's estate.

If any benefit under the policy becomes payable to an Insured’s estate, a minor, or any person who, in Our opinion, is not competent to give a valid release, then We, at Our option, may make payment to any one or more of the following:

a. a person who has assumed the care and support of the Insured or beneficiary;
b. a person who has incurred expenses not to exceed $500 as a result of the Insured’s last illness or death;
c. the personal representative of the Insured’s estate;
d. any person related by blood or marriage to the Insured.

Any payment we make shall discharge us from liability to the extent of that payment. We are not obligated to see that the payment(s) are properly used.

Death benefit proceeds shall be paid to the beneficiary in one lump sum in the amount specified in the Schedule of Benefits.

The Insured may elect to have all or any part of the insurance for loss of life paid out to the beneficiary in installments or in any other way that may be agreed to by Us. To elect, the Insured must give notice to Us in writing. The Insured will have the right to change such election. The terms of payment will be in accord with those offered by Us for the insurance at the time election is made.

After the Insured's death, the beneficiary:

a. may make such an election, if the insured had not done so; and
b. may name person(s) to receive any amount which, if no person(s) were so named, would go to the beneficiary's estate; and
c. will have the right to change the person(s) name in accord with b.

Two or more beneficiaries in the same class shall share equally unless otherwise provided.

[Benefits payable under this Policy on the death of a Dependent will be paid to the Employee in one lump sum. If the Employee dies prior to the Dependent, the Company will pay the benefit to the Employee's estate.]

MISSTATEMENT OF AGE

If the age of an insured has been misstated there will be a fair adjustment of premium. If the benefit for the insured is based on age, there will be an adjustment of benefit to that amount which the premium being paid would purchase at the correct age.

We have the right to require satisfactory proof of age.

ASSIGNMENT

We will not be bound by any assignment of this policy by you unless:

1. it is in writing and
2. it is filed at our Home Office

We will not be responsible for the validity of any assignment.

CLAIMS OF CREDITORS

To the extent allowed by law, benefits will be exempt from creditors.

FE INSURANCE

PART 1. DEATH BENEFIT

When We receive due proof of the death of an Insured Individual or Dependent who is insured under this policy for this coverage, We will pay at Our Home Office, the amount for which his or her life is insured as shown in the Schedule of Benefits. Payment will be made to the beneficiary in accord with the terms of the policy.

[DEATH BENEFIT NOT COVERED

1. Suicide committed during the first two years of coverage. Any premium received during this two year period while insured will be refunded.
2. Aviation other than as a fare paying passenger on a scheduled or charter flight operated by a scheduled airline.]

PART 2. CONVERSION

An Insured Individual or Dependent may elect to buy an individual life insurance policy if his or her Life Insurance is reduced or ends because of:

1) termination of employment;
2) termination of membership in the class or classes eligible for coverage under the policy;
3) termination of the policy;
4) attainment of a particular age;
5) change in class; or
6) amendment of the policy.

No evidence of good health will be required for the converted policy. The converted policy may be on any of the forms We then issue, except:

1) it may not provide term insurance except as stated below;
2) it may not provide benefits for disability;
3) it may not provide extra benefits for accidental death;
4) it must meet Our issue rules as to amount and age.

The person may choose to have the converted policy preceded by term insurance for not more than one year with premiums payable at the same frequency as for the conversion policy.

The person must apply to Us and pay the first premium for the converted policy. If the person is notified of the right to convert within 15 days before or after the change in Life Insurance, this must be done within 31 days of the change. Then the converted policy will take effect 31 days after the change. If the person is not notified in that period, the time to apply to Us is extended to the earlier of 45 days after notice is given or 90 days after the change. Then the converted policy will take effect on the later of 31 days after the change or when the first premium is paid.

The premium for the converted policy will be based on:

1) attained age,
2) class of risk, and
3) amount of the policy.

The amount of the converted policy may not exceed:

1) the amount for which the person was covered under this policy, less
2) any amount for which the person is eligible under this policy or becomes eligible under any other group policy in the 31 days after the change.

If the person dies within 31 days after the change, We will pay to the beneficiary, in accordance with the terms of the policy, the amount of the life insurance that could have been converted.

No payment will be made if: (i) at the death of the Dependent he or she is eligible for life insurance under this policy as an Individual, or (ii) at the date of a child's death, he or she is married or has reached the age limit.

The incontestability period does not start anew, but is effective as of the date the original group policy coverage was issued.

[ENDORSEMENT AND RIDER FORMS ATTACHED TO THE CERTIFICATE

The following table sets forth the list of any Endorsements & Riders attached to the Certificate.

Form	Form Number	Effective Date

]

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue, White Plains, NY 10604

Amalgamated Life Insurance Company ("we", "us", "our") has issued this Rider as part of the Certificate to which it is attached. The effective date of this Rider is [the Certificate Date shown in the Certificate Schedule/ the Effective Date shown in the Notification of Certificate Change Endorsement]. Except as shown in this Rider, the provisions of the Certificate will prevail.
PLEASE READ THIS RIDER CAREFULLY.

ACCIDENTAL DEATH [& DISMEMBERMENT] BENEFIT RIDER

WHAT IS COVERED
We will pay the applicable benefit amount for an accidental death or dismemberment resulting from accidental bodily injury and incurred by the Insured. Payment is subject to receipt of due proof of the Accidental Death or Dismemberment of the Insured. The Loss must have occured: (a) within ninety days after the accident causing such Loss; (b) while this Rder is in force.

[All benefits other than for loss of life will be paid to the Individual.] Benefits for loss of life will be paid to the Insured's beneficiary.

The amount shown in the Schedule of Benefits for Accidental Death [& Dismemberment] is paid for loss of [life.[:]]

	[Any two or more:
Life	One foot,
[Both hands or both feet	One hand,
Sight of both eyes	Sight of one eye
Speech & Hearing]	Speech
	Hearing

[One-half the amount shown in the Schedule of Benefits is paid for loss of:

One hand or
One foot or
Sight of one eye
Speech
Hearing]

[Loss means a) severance of hand or foot at or above the wrist or ankle joint; b) the total and irrecoverable loss of sight; c) total and irrecoverable loss of audible speech communication; d) total deafness in both ears, which cannot be corrected to any functional degree by any aid or device.]

[If more than one loss is suffered in any one accident, payment will be made only for the loss with the largest benefit. Payment will be made only for the loss that results from the accident without regard to any former loss.]

[If the Insured becomes paralyzed as a direct result of an accidental bodily injury sustained while covered under this Rider, the benefit percentages listed below are payable. Paralysis must occur within one year from the date of the accident causing the paralysis. The benefit payable is a percentage of amount shown in the Schedule of Benefits for Accidental Death [& Dismemberment], and is as follows:

- Quadriplegia (complete and irreversible paralysis of both upper and both lower limbs) 100%
- Paraplegia (complete and irreversible paralysis of both lower limbs) 75%
- Hemiplegia (complete and irreversible paralysis of upper and lower limbs on one side of the body) 50%
- Uniplegia (total paralysis of one limb) 25%]

[If the Insured suffers a covered loss under this Rider, which is the result of a felonious assault, we will pay an additional benefit equal to the lesser of [10%] of the benefit amount in the Schedule of Benefits or [$25,000].

"Felonious Assault" means a physical attack by another person resulting in bodily harm. A physical attack is any willful or unlawful use of force or violence with the intent to cause bodily injury. The physical attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs. The felonious assault must not be either a moving violation as defined under the applicable state motor vehicle laws or an act of an immediate family member or a person residing in the same household.]

NOT COVERED

[No benefits will be paid for loss resulting from or caused directly or indirectly by:

1. War or any act of war, whether declared or undeclared, terrorism, insurrection, rebellion, or participation in a riot or civil commotion;
2. Sickness, disease or bodily infirmity. (This does not include bacterial infection which results from an accidental cut or wound or accidental ingestion of a poisonous food substance;
3. Taking a poison or asphyxiation from or inhaling of gas, or intentionally taking narcotics, drugs, barbiturates, hallucinogenic drugs, alcohol or any combination of these when not part of a professional medical treatment;
4. Intentionally self inflicted injury, while sane or insane;
5. Suicide or attempted suicide, while sane or insane;
6. Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft then licensed to carry passengers
7. Commission of or participation in a crime]

NO RIGHT TO CONVERT

The coverage provided by this rider may not be converted.

NOTICE OF CLAIM

Written notice of the event on which claim is based must be given to us at our Home Office no later than thirty days after the loss for which claim is made. Late notice will be accepted if it is shown to have been furnished as soon as it is reasonably possible; in the absence of any adequate explanation, a late processing fee up to [$500] may be charged against benefits payable.

On receipt of such notice we will furnish forms for filing proof of claim. If the claimant has not been given such forms within fifteen days after receipt of notice that person can fulfill the terms of the policy as to proof of claim by giving written proof of:

1. the occurrence of the loss;
2. the nature of the loss; and
[3. the extent of the loss.]

Such proof must be given within the time stated in "PROOF OF CLAIM" below.

PROOF OF CLAIM

Written proof of claim must be given to us at our Home Office on our forms within ninety days after the date of loss for which claim is made.

Late proof will be accepted if it is shown to have been furnished as soon as it is reasonably possible.

PAYMENT OF CLAIMS

On receipt of due proof of claim:

1. benefits for loss of life will be paid in accord with the terms of this policy; and
2. all other benefits will be paid to the Insured [; a late processing fee up to [$500] may be charged against benefits payable if late proof cannot be justified based on grounds of extenuating circumstances].

EXAMINATIONS

We, at our own expense, have the right to have a doctor examine any Insured when we deem it reasonably necessary while there is a claim pending under this policy. We also have the right to make an autopsy in case of death where the law does not forbid it.

LEGAL ACTIONS

No one may sue for payment of claim: (1) less than sixty days after due proof of claim is furnished; or (2) more than three years after the date proof of claim is required by this policy.

David J. Walsh
President

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue, White Plains, NY 10604

Amalgamated Life Insurance Company ("we", "us", "our") has issued this Rider as part of the Certificate to which it is attached. The effective date of this Rider is [the Certificate Date shown in the Certificate Schedule/ the Effective Date shown in the Notification of Certificate Change Endorsement]. Except as shown in this Rider, the provisions of your Certificate will prevail.
PLEASE READ THIS RIDER CAREFULLY.

ACCIDENTAL DEATH [& DISMEMBERMENT] ("AD[&D]") SEAT BELT AND AIR BAG BENEFIT RIDER

WHAT IS COVERED

If the Insured dies as a result of a motor vehicle accident while covered under the policy and while driving or riding as a passenger in an automobile, we will pay an additional benefit equal to the lesser of **[25%]** of the Insured's AD[&D] benefit amount or **[$25,000].**

This benefit is in addition to any other benefit paid under the AD[&D] rider and will be paid when we receive proof that:

1. The Insured death was a result of the accident;
2. The Insured died of a cause not excluded under the AD[&D] rider.
3. The Insured died while coverage under the policy was in force;
4. The Insured died within one year of the accident;
5. The automobile was equipped with seat belts at the time of the accident;
6. The Insured seat belt was in actual use and was properly fastened at the time of the accident; and
7. Position of the seat belt is certified in the official accident report, or by the investigating officer.

A copy of the police report must be submitted with the claim. If such certification is not available, and it is unclear whether the Insured was wearing a seat belt, we will pay a fixed benefit equal to [$1,000] to the Beneficiary.

If the benefit is payable under the Seat Belt Benefit and the automobile is equipped with a factory installed Air Bag system, we will pay instead an additional benefit of the lesser of **[10%]** of the Insured's AD&D benefit amount or **[$10,000]** if:

1. The Insured is positioned in a seat that is designed to be protected by an air bag; and
2. The air bag inflated properly upon impact and is certified in the official accident report, or by the investigating officer.

"Automobile" means a motor vehicle licensed for use on public highways.

"Seat Belt" means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat belt will include a lap belt alone, but only if the automobile did not have a combination lab and shoulder restraint system when manufactured. Seat belt does not mean a shoulder restraint alone.

EXAMINATIONS

We, at our own expense, have the right to have a doctor examine any insured when we deem it reasonably necessary while there is a claim pending under this policy. We also have the right to make an autopsy in case of death where the law does not forbid it.

LEGAL ACTIONS

No one may sue for payment of claim: (1) less than sixty days after due proof of claim is furnished; or (2) more than three years after the date proof of claim is required by this policy.

David J. Walsh
President

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue, White Plains, NY 10604

Amalgamated Life Insurance Company ("we", "us", "our") has issued this Rider as part of the Certificate to which it is attached. The effective date of this Rider is [the Certificate Date shown in the Certificate Schedule/ the Effective Date shown in the Notification of Certificate Change Endorsement]. Except as shown in this Rider, the provisions of your Certificate will prevail.
PLEASE READ THIS RIDER CAREFULLY.

ACCIDENTAL DEATH [& DISMEMBERMENT] ("AD[&D]") REPATRIATION OF REMAINS BENEFIT RIDER

WHAT IS COVERED

If the Insured dies as a result of a covered injury sustained outside the Insured –country and a principal sum is payable under the policy for AD[&D] benefits, we will pay, in addition to the AD[&D] Benefit, the Repatriation Benefit which provides reimbursement for covered expenses reasonably incurred to transport the Insured's body by the most direct and economical route to his or her country.

The Repatriation Benefit is equal to the reasonable expenses incurred to a maximum of **[$5,000]** for the following services:

1. Documentation and authorization from local authorities;
2. Embalming or cremation;
3. A coffin or urn appropriate for the transportation of mortal remains; or
4. Transportation of the mortal remains to the funeral director responsible for burial.

The benefit is payable to the person who has incurred the cost for any of the covered services indicated above.

"Country" means the nation in which the Insured maintains legal residence.

"Reasonable Expense" means the usual and customary fee or charge for the services rendered and the supplies furnished in the area where services are rendered or supplies furnished.

LEGAL ACTIONS

No one may sue for payment of claim: (1) less than sixty days after due proof of claim is furnished; or (2) more than three years after the date proof of claim is required by this Rider.

David J. Walsh
President

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CONTINUATION OF COVERAGE RIDER

If, after you become insured, you are no longer eligible for standard benefits under the Group Policy, you may have the option to continue this insurance by paying the premium directly to us. You may elect this option only if your premiums are not already being waived under a Waiver of Premium Rider.

NOTICE OF CONTINUATION COVERAGE

If this insurance is about to stop, the Group Policyholder/Participant Employer will remind you of the Rider by giving you a written notice. If you decide to exercise the option to take advantage of this Rider, you must inform us in writing within 31 days (called the continuation period) after this insurance stops. We will send you an application to fill out and let you know (1) the amount of premium you will have to pay to us, (2) the frequency at which premiums will be payable, and (3) the amount of any billing fee. The effective date of the continued coverage will be the date you applied for the continuation.

If an insured dies during the continuation period, we will still pay death benefit even if you have not asked for to elect this option. However, we will reduce the death benefit by the amount of premium necessary to provide insurance to the date of death.

TERMINATION OF COVERAGE

Coverage continued under this option will stop on the earliest of : (1) [31] days after a premium due date, if you stop paying premium; (2) the date this insurance is converted to permanent insurance; or (3) the date the Group Policy stops.

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President

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WAIVER OF PREMIUM BENEFIT RIDER

Subject to the terms of this Rider, we will waive certain premiums when we receive proof that the Insured becomes totally disabled by injury or disease, before reaching age [60] and while this Rider is in force. We will continue to waive premiums becoming due for up to one year from the start of the disability, while the Insured remains so disabled. After that, proof of continued disability of the Insured must be given to us [3] months before each anniversary of the start of the disability.

Due proof of the Insured's total disability must be given to us within [12] months of the date disability began. ["Totally disability" means the Insured [is unable to perform any occupation for which he or she is qualified by education, training, or experience and has not received pay for any work for [9] continuous months.] ["Total disability" means the complete inability, due to injury or illness, to engage in any business, occupation, or employment, for which he or she is qualified or becomes qualified by reason of education, training, or experience for pay, profit or compensation. Additionally, to be eligible for the Waiver of Premium benefit, the Insured must be totally disabled for [9] continuous months.]

If the Insured has converted his or her group life insurance coverage while disabled, he or she must return the individual policy to us with first proof of total disability. Any premiums paid under that policy will be refunded.

While the Insured is so disabled, he or she will be covered for the amount of life insurance for which he or she was insured just before ceasing active work due to total disability. This amount is subject to reduction, if any, as shown in the Certificate.

We have the right to have the Insured examined by our medical representative when necessary, but not more than once a year after total disability has continued for two full years.

Proof that total disability lasted until the Insured's death must be given to us within one year after the date of death. Upon our receipt of that proof, we will pay the Insured's beneficiary the amount of Life Insurance for which he or she was last insured.

The individual's protection under the rider will end [31] days after he or she: (a) ceases to be totally disabled; or (b) fails to give required proof of continued disability; or (c) fails to submit to a health examination;[or (d) he/she reaches [the earlier of age [65]] [or the age at which he/she completed [five (5)] years of being on total disability] [or the age at which his/her normal retirement begins under his/her employer's retirement plan].

When this protection ends, he or she will have the same rights as those described under Conversion provision of this Policy, unless he or she becomes insured again under this policy by again paying premium.

If the Insured dies after his or her insurance has been converted, any amount paid under the individual policy will be deducted from the amount of group life insurance coverage due under this policy. Any premiums paid under the individual policy will be paid to the beneficiary of that policy on return of that policy to us.

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REDUCTION OF DEATH BENEFIT ENDORSEMENT

Amalgamated Life Insurance Company ("we", "us", "our") has issued this Endorsement as part of the Certificate to which it is attached. The effective date of this Endorsement is [the Certificate Date shown in the Certificate Schedule/ the Effective Date shown in the Notification of Certificate Change Endorsement]. Except as shown in this Rider, the provisions of your Certificate will prevail.
PLEASE READ THIS RIDER CAREFULLY

The Benefit Amount in effect on each Insured Member and/or Insured spouse will automatically reduce after the Group Policy Anniversary immediately following such Insured's [65th] birthday. The amount will be the applicable percentage of Benefit Amount as shown below:

Member's [/ Spouse's] Birth Day	[Percentage of Benefit Amount]			
	Life		[AD[&D]	
	Member	[Member's Spouse	Member	Member's Spouse
[65th]	[92%] of pre-age [65] death benefit	[92%] of pre-age [65] death benefit	[92%] of pre-age 65 death benefit	[92%] of pre-age [65] death benefit
[66thj]	[85%]	[85%]	[85%]	[85%]
[67th]	[78%]	[78%]	[78%]	[78%]
[68th]	[72%]	[72%]	[72%]	[72%]
[69th]	[66%]	[66%]	[66%]	[66%]
[70th]	[61%]	[61%]	[61%]	[61%]
[71st]	[56%]	[56%]	[56%]	[56%]
[72nd]	[52%]	[52%]	[52%]	[52%]
[73rd]	[48%]	[48%]	[48%]	[48%]
[74th]	[44%]	[44%]	[44%]	[44%]
[75th]	[41%]	[41%]	[41%]	[41%]
[76th]& Later	[38%]	[38%]]	[38%]	[38%]]

The member's coverage automatically terminates when his/her membership with the Group Policyholder ends. The spouse's and/or dependent child's coverage terminates on the earlier of: (1) the date the Member's coverage terminates; (2) upon attainment of the maximum age limit; or (3) when he/she no longer meets the definition of an eligible spouse or child.

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ACCELERATED BENEFIT RIDER

This Rider provides for the accelerated payment of a portion of the Certificate Death Benefit applicable to the Certificate Holder[, his/her covered Spouse, and covered Dependent Child(ren)] named in the Certificate if all requirements of this rider are met and the Insured, covered spouse or covered dependent child of the Insured named in the Certificate is diagnosed with a terminal condition as defined in this rider.

The amount of accelerated benefit will be [25% to 50%] of the Certificate Death Benefit that is scheduled to be in effect one year from the date an accelerated benefit is requested. The amount so payable will in compliance with the requirements of the state in which the policy is delivered.

The Accelerated Benefit[, less any administrative charge,] will be paid in a lump sum and any remaining Death Benefit under the Certificate will be reduced by the amount of Accelerated Benefit. The amount of any Accidental Death Benefit will not be affected by the payment of the Accelerated Benefit. Premium must continue to be paid for the Insured under the Group Policy after payment of an Accelerated Benefit in order to keep the remaining Certificate Death Benefit in force.

Receipt of Accelerated Benefit may affect eligibility for public assistance programs and may be taxable. Please consult a personal tax advisor to determine the tax status of any benefits paid under this rider.

DEFINITIONS

The following definitions shall constitute the meaning of the terms used in this Rider.

Accelerated Death Benefit: The amount payable by Amalgamated Life Insurance Company to the Insured under this Rider.

Certificate Death Benefit: The amount listed on the Certificate of Insurance reduced by the amount of any Accelerated Benefit paid.

Insured: The Individual named as the Insured in the Certificate.

[Administrative Charge: The amount of Accelerated Benefit is reduced as a result of the administrative cost to Amalgamated Life Insurance Company in processing the Accelerated Benefit claim. The administrative charge shall be [$75].]

Physician: A Physician is a licensed medical doctor (M.D.) or doctor of osteopathy (D.O.) A Physician does not include the Insured, any person who lives with the Insured or a spouse, child, parent, brother, sister, grandparent, grandchild, or spouse of such relative, of the Insured or Insured's spouse.

Terminal Condition: A condition caused by sickness or accident which, in the judgment of a Physician and subject to the approval of the Company, will directly result in a life expectancy of twelve months or less.

We may require a second opinion and examination of a covered individual. It will be at the Company's expense by a licensed physician chosen by the Company. If there is a discrepancy between the two medical opinions, the opinion of the Company Physician will govern

GENERAL

Frequency: Only one Group Living Benefit will be paid for the Insured[, his/her covered Spouse, and covered Dependent Child].

Incontestability: The Incontestability Clause as written under the Certificate of Insurance shall apply to this Rider.

TERMINATION OF COVERAGE

The coverage under this rider will terminate for the Insured:

1. Upon written request to cancel by the group policyholder;
2. Upon termination of the Group Policy/Certificate;
3. If the Insured is no longer a member of the class(es) of insureds as defined in the Group Policy;
4. The date of the Certificate Holder's death;
5. After payment of the Accelerated Benefit.

EXCEPTIONS AND LIMITATIONS

This benefit provides for the accelerated payment of life insurance proceeds. It is not meant to cause the Certificate Holder to involuntarily invade proceeds ultimately payable to the named beneficiary. The accelerated benefit will be made available on a voluntary basis only. Therefore, if it is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, the applicant is not eligible for this benefit. Or, if required by a government agency to use this option to apply for, obtain, or keep a government benefit or entitlement, the applicant is not eligible for this benefit.

If the amount of term insurance in force on the Insured is scheduled to reduce because of an age related reduction, within one (1) year after the date he/she applies for a Accelerated Benefit, the maximum Accelerated Benefit will be limited to the scheduled reduced amount shown on the Policy Schedule.

No Accelerated Benefit will be paid to the Certificate Holder if:

1. The Certificate Holder made an absolute assignment or an irrevocable beneficiary designation of his/her group term life insurance, unless the absolute assignee or irrevocable beneficiary provides the Amalgamated Life Insurance Company with written consent to the acceleration.

2. The Insured's Terminal Condition resulted, directly or indirectly, from suicide or any self-inflicted injury, committed while sane or insane.

3. When all or a portion of the Certificate Holder's life insurance benefits are paid as a part of a divorce settlement.

4. If the required group life premium is due and unpaid.

TAX CONSIDERATIONS

This rider is intended to provide an Accelerated Death Benefit that qualifies as such under the Internal Revenue Code (IRC). Tax liability for any Accelerated Death Benefit payable under this rider may depend upon a number of factors including how the Internal Revenue Service interprets applicable provisions of the IRC. The Insured should consult a tax advisor to consider any tax consequences that may arise when benefits are paid under this rider.

OTHER FINANCIAL CONSIDERATIONS

If the Insured receives benefits under this rider, eligibility for certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security Income (SSI), and other government assistance benefits may be affected.

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President

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GROUP INSURANCE APPLICATION

Application is hereby made to Amalgamated Life Insurance Company ("Amalgamated") on the basis of the data contained in this application, the group risk factors, the enrollment data and available experience data. The application in its entirety, and any required additional data, is subject to Amalgamated's approval before insurance can become effective.

If this application is approved by Amalgamated, it will be attached to and made part of the Group Polic(y)(ies). Insurance will become effective on the requested effective date shown below unless Amalgamated sends written notice of a different effective date.

If this application is not approved by Amalgamated, no insurance is in effect at any time and any deposit premium Amalgamated has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the [first month]; and will be applied toward the first premium on the proposed Group Policy(ies); $ _____.

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective. Requested effective date; _____.

Coverage(s) being applied for:

___ Life
___ AD&D Rider
___ Other Rider _____
___ Short Term Disability
___ Long Term Disability

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):

___ Option 1: Withhold state and federal income taxes and the employee's portion of FICA.
Prepare and file W-2 Forms.
___ Option 2: Withhold federal income taxes and the employee's portion of FICA.
Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured?
____ Yes ____ No If yes, please furnish a listing, giving the name, address, effective date of coverage, and number of employees for each such company.

Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended? ____ Yes ____ No
If yes, identify the Plan Number: _____

Sales Representative for Amalgamated: _____

Regional Office: _____ Name of Agent/Broker: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For Applicant**:*

_____
Legal Name of Entity

_____ _____
Signature Date

_____ _____
Name and Title of Authorized Signature. Employer Tax Id No.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, New York 10604
LIFE INSURANCE AND DISABILITY ENROLLMENT FORM

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name Last	**First**	**M.I.**	**Birth Date: MM/DD/YY**

Social Security No.	**Sex** ☐ **M** ☐ **F**	**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	**Date of Marriage**: **MM/DD/YY**

Employee Home Address Street	**City**	**State**	**Zip**

Dependent Information (complete only if coverage is available & elected) (Dependent Life only)

	Last	**First**	**M. I.**	**Sex: M/F**	**Birth Date: MM/DD/YY**
Spouse					
Child					
Child					
Child					

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (*You will not be covered for coverages not included in your Employer's contract*.) To elect coverage check the box marked "Y". To decline coverage check the box marked "N"

Basic Life ☐Y ☐N Amt $_____	**Supp Life** ☐ Y ☐ N Amt $_____ Basic Income $_____ Other	**AD/D** Rider ☐ Y ☐ N **Other Rider** (please specify) _____ _____	**[Weekly] Disability** ☐Y ☐N Flat Amt $_____	**LTD** ☐ Y ☐ N Amt $_____

Dependent Life Spouse ☐ Y ☐ N Amt $_____ Child ☐ Y ☐ N Amt $_____	**Supplemental Life** ☐ **Y** ☐ N	**LTD Buy-Up** Option 1 _____% Option 2 _____%

Beneficiary Designation - Please refer to the reverse side for important information regarding beneficiary designation.

Full Name Address SSN Relationship DOB

Primary _____

Contingent _____

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed. I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Amalgamated Life and my Group Plan.

☐ I hereby waive coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability that is satisfactory to Amalgamated Life, before my coverage will become effective.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

Policy Symbol	Policy Number	Bill Unit	Loss Unit	Original Effective Date of Policy
Employer Name	Employee Hire Date	Effective Date of Coverage		
Employee Occupation	Employee Class	Life [Weekly] Disability LTD		
Salary $_____ ☐Annual ☐Monthly ☐Weekly ☐Hourly				
Termination Date		Reinstatement Date		

NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage insert the words, **"Not related."** If you need assistance, contact your company representative or your own legal counsel.

Following are examples of the most common designations:

Mary J. Doe, Wife (not Mrs. John Doe).

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.

Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

If you find that more space is needed for naming your beneficiary(ies) than provided on this form please attach a separate sheet(s). Sign and date each sheet.

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EVIDENCE OF INSURABILITY FORM

[Applicants] must complete this form if they have requested insurance coverage for themselves [or any of their family members] and are required to show evidence of good health. For questions about how to complete this form, call Amalgamated Life Insurance Company (the "Company") at **[1-800-331-7234]**

Upon Completion: Send [both the [Policyholder] and [Applicant] sections of] this form to:
Amalgamated Life Insurance Company
Group Life & Health Insurance Underwriting
[P.O. Box 2999, Amalgamated, CT 06014-2999]

Please remember your form can not be processed without your signature and current date.
Please keep a copy of the completed forms for your records.

Check Applicable Coverage	☐ **Life Insurance**	☐ **Short Term Disability**	☐ **Long Term Disability**

[INSTRUCTIONS

[[Policyholder's] Responsibility

1. Fill out the [Policyholder] Section completely. Please note an incomplete form will result in a delay in processing your request for insurance. Refer to your Policy and employee records. [These records are your property and are not on file with the Company's Group Medical Underwriting Unit.]
2. In Section #1 of this [application] form ("Who Requires an [Application]?") indicate with a check mark all who are required to provide evidence of good health – [employee, spouse or child- and for each,] and check the reason(s) why. Refer to your Policy and employee records for all requirements, limitations and exceptions. Employees or spouses signing up after their new hire eligibility period will be responsible for any underwriting costs.
3. In Section (#2 "Coverage Summary,") complete all coverage amounts for each [Applicant]. **[Basic Life Coverage is important and required for all [Applicants] requesting additional Life coverage.]** refer to your employee records to find current coverage amounts. Please note that the Company does not have access to employee records for coverage amounts.
4. Complete the [Policyholder] section and forward the entire form to the employee who needs evidence of insurability.
5. No premiums should be deducted for additional amounts until a final decision regarding coverage is received from the Company's Underwriting Unit.**]**

[[Applicant's] Responsibility

1. [Make sure your Employer has already completed the [Policyholder] Section of this form in full.]
2. [The [Policyholder] Section clarifies which [Applicants] need to show evidence of good health and should be listed on this [application] form. Refer to ("Who Requires an [Application]?") in the **[Policyholder] Section** of the form where a box has been marked for each person who is required to fill out this [Application] form - [you (the employee), your spouse or child.] Enter the names of these individuals on the [Application] under "[Applicants] Requiring Health Evaluation," and fill in the information requested.]
3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.
4. An [Applicant] who has not enrolled by the end of the new hire eligibility period (shown in the [Policyholder] Section #1) will be responsible to pay for the cost of physical exams, medical records or medical tests if they are required during the underwriting process.
5. YOU, THE [EMPLOYEE] MUST SIGN THIS FORM (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. [Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature and enter the date signed.]
6. **[BOTH THE [EMPLOYER] AND [EMPLOYEE] SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY THE COMPANY WITHIN [30 DAYS] OF THE SIGNATURE DATE.]**
7. The medical and personal information you complete on this form will be considered "current" for [90 days]. Leaving information blank can result in delays or may result in your file being closed.

]

[POLICYHOLDER INFORMATION

[Policyholder] Section Please print in blue or black ink. Initial any changes. Do Not Erase			
[Policyholder] Name:			
[Division/Subsidiary Name:]			
[Participating Organization:]			
[Policy No.]			
[Certificate No.]			
[Policy Effective Date]			
[Mailing Address: Street:	City:	State:	Zip Code:]
[Benefits Contact Person (If Applicable): Telephone Number:		E-Mail:]	
[[Applicant] Name/[Applicant] Social Security Number/Date of Hire/Family Status Change Date/[Applicant] Base Annual Earnings (BAE)$]			

]

PROPOSED INSURED INFORMATION

[Applicant]/Proposed Insured Information Section Please print in blue or black ink. Initial any changes. Do Not Erase	
Answer all the questions. DATE and SIGN this form in all areas indicated	Mail the completed [Policyholder] and [Applicant] section(s) to: Amalgamated Life Insurance Co. Group Life & Health Ins. Underwriting [P.O. Box 2999 Amalgamated, CT 06104-2999]

[Applicant's] Name (First, Middle Initial, Last)			
☐Male ☐Female			
Height:___ft. ___in			
Weight: _____lb.			
Social Sec. No.:			
Mailing Address: Street:	City:	State:	Zip Code
Phone Number (Daytime/Evening):			
Date of Birth:			
[Age Last Birthday:]			
Place of Birth: (Town, State, Country)			
[Occupation/Title:]			
[Position/Duties:]			
[Date of Hire]			
Effective Date			
[Business Address: Street:	City:	State:	Zip Code:]
[E-Mail:]			
[Can we call you for any additional or missing information? YES: ☐ NO ☐What is the best time to call you?]			
[Business Telephone:]			

[1.Who requires an [Application]
Check box for each [Applicant] who requires evidence of good health with an [Application], and specify the reason(s) why.
Check all reasons that apply. Identify all [Applicants] requiring an [Application].

[IEE Employee	☐**New Hire** Newly hired employee electing coverage for the first time during normal eligibility period.*	☐**Over Guaranteed Issue ("GI") Limit** Election being made that requires medical underwriting, as it is above the GI limit*	☐**Opting up to Higher Level of Coverage** e.g. from 1 to 2 times salary or increasing in specified incremental dollar amounts as allowed by the plan.*	☐**Late Entrant** Employee who enrolled outside one of the following eligibility periods, usually 31 days from date of hire or from date of family status change, or an open enrollment.*	☐**Change in Family Status** Employee change in coverage being made within 31 days of a qualified change in family status.* (marriage, divorce, birth of a child, etc)**]**
[SP Spouse	☐**New Hire** Spouse electing coverage for the first time with a newly eligible employee during normal eligibility period.	☐**Over Guaranteed Issue Limit** Election being made that requires medical underwriting, as it is above the GI limit.*	☐**Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.*	☐**Late Entrant** Spouse did not enroll during one of the following eligibility periods: usually 31 days from employee date of hire or from date of family status change*	☐**Change in Family Status** Newly eligible spouse qualifies for GI coverage if elected within 31 days of the change in family status.***]**
[CH Child	☐**New Hire** Child electing coverage for the first time with a newly eligible employee during normal eligibility period.	☐**Over Guaranteed Issue Limit** Election being made that requires medical underwriting, as it is above the GI limit.*	☐**Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.*	☐**Late Entrant** Child did not enroll during one of the following eligibility periods: usually 31 days from employee date of hire or from date of family status change.*	☐**Change in Family Status** Newly eligible child qualify for GI coverage if elected within 3 1 days of the change in family status.***]**

*Please Refer to your policy and employee records for coverage amounts, eligibility periods (for Late Entrant determination), Guaranteed Issue limits, exceptions for salary increases and rules for "opting up." Please check the policy guidelines for Change in Family Status rules and exceptions. **]**

[

[Applicants] Requiring Health Evaluation (This is critical information and if left blank there will be a delay in processing.) List below the names of [Applicants] identified in Section 1.								
First Name, M.I., Last Name	**[APPLICANTS]**	**HEIGHT (ft/in) Required**	**WEIGHT (lbs) Required**	**DATE OF BIRTH Required Month**	**Day**	**Year**	**GENDER**	
[	[Applicant]						M	F]
[	Spouse						M	F]
[	Child						M	F]

]

[

If Dependent Coverage is desired, complete the following:				
Full Name	Relationship	Birth Date	Height	Weight

]

[OTHER INSURANCE INFORMATION

Does anyone proposed for coverage have any [Life/Disability Income] Insurance in force or pending with this or any other company? ☐Yes ☐No If yes, give details:

Name	Company	Face Amount	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	No

]

[Please check "Yes" or "No" By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? ☐Yes ☐No **]**

[COVERAGE REQUESTED

[COVERAGE REQUESTED: ☐ New Coverage ☐ Change in Coverage

Disability Income

[Weekly] Benefit Amount: _____ Payment Period Option: _____ Waiting Period Option: _____

Is the [Weekly] Benefit Amount herein applied for equal to or less than [60%] of your Basic [Weekly] Pay minus any Other Income Benefits? ☐ Yes ☐ No **]**

[Life Insurance Amount Desired ([$10,000] minimum up to [$100,000] maximum in [$10,000] increments) _____

_____
[Proposed Insured]

[_____
Spouse

Please indicate if request is for ☐New Coverage

☐Change in Coverage

The Spouse may not be covered under a Plan with benefits greater than the Member's Plan.]

[IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT ONLY THE ADDITIONAL AMOUNT DESIRED]

]]

[2. Coverage Summary - For each [Applicant,] complete all three columns

[Life Coverages: Be sure to include any in force Basic Life coverage as a dollar amount for all [Applicants] requesting supplemental life coverage. Refer to employee records for Current Coverage Amounts. For most policies, Life coverage can be calculated as 1, 2, 3 etc. times salary or in dollar amount increments for increment plans.**]**

[[Applicants] for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first lime. If late entrant this amount should be zero)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
Employee: Basic Life Salary multiples for BAE plans	**Required if Basic Coverage offered** **$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**
Employee: Supplemental Life or Voluntary Life Salary Multiples for BAE	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple]**

[Coverage Summary (continued from previous page)]			
[[Applicants] for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first time. If late entrant this amount should be zero)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
[Spouse: Basic Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**
Supplemental Life or Voluntary Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __]**
[Child: Basic Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**
Supplemental Life or Voluntary Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __]]**
[Long Term Disability Coverage: Refer to employee records for the benefit percentage selected and calculate that percentage of their annual salary. Then calculate the monthly benefit amount by dividing by 12. **]** **[Short Term Disability Coverage:** Refer to employee records for the benefit percentage selected and calculate that percentage of their annual salary. Then calculate the weekly benefit by dividing by 52.**]**			
[[Applicants] (employees only)	**Current Benefit Amount**	**Additional Benefit Amount**	**Total Benefit Amount**
[Employee: Long Term Disability	**$___ ___, ___ ___ ___ per month**	**$___ ___, ___ ___ ___ per month**	**$___ ___, ___ ___ ___ per month]**
[Employee; Short Term Disability	**$___ ___, ___ ___ ___ per week**	**$___ ___, ___ ___ ___ per week**	**$___ ___, ___ ___ ___ per week]]**

]

[The following costs were calculated based on your age as of [January 1, 2009], your [annual salary of $50,000] and [12 (Monthly) deductions]. Your employer gave this information to the Company. Please contact your benefits administrator immediately if it is incorrect.

[Voluntary Long Term Disability Insurance

You have the opportunity to enroll in [the Company's Voluntary Long Term Disability (LTD) insurance plan]. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been Disabled for a predetermined waiting period, known as the elimination period, of [180 days]. This plan provides you with income protection to replace up to [60%] of your regular pay, to a maximum monthly benefit of [$5,000].

☐ I **elect** to enroll in the Voluntary LTD plan at a [monthly] cost of [$ 1.00.*]
☐ I **decline** to enroll in the Voluntary LTD plan.

*Your cost may change if your salary changes within the benefits plan year.**]**

[The following costs were calculated based on your age as of [January 1, 2009] and [12 (Monthly) deductions.] Your employer gave this information to the Company. Please contact your benefits administrator immediately if it is incorrect.

[Voluntary Short Term Disability Insurance

You have the opportunity to enroll in [the Company's Short Term Disability (STD) insurance plan.] STD insurance helps to replace your income if you are sick or injured and cannot work. This coverage commences on the [1st] day of accident and the [8th] day of sickness and is designed to continue for a period of [13] weeks.] This plan provides you with income protection to replace up to [60%] of your earnings, to a maximum pay period benefit of [$1,000.]
☐ I **elect** to enroll in the Voluntary STD plan at a [weekly] cost of [$1.00.*]
☐ I **decline** to enroll in the Voluntary STD plan.
*Your cost may change if your salary changes during the plan year.**]**

[Supplemental Life Insurance – Employee

You have the opportunity to enroll in [the Company's Supplemental Life Insurance plan.] Your election may be made in increments of [$10,000], not to exceed [3] times your salary or [$350,000], whichever is less. If you elect an amount that exceeds the lesser of [3] times your salary or the guaranteed issue amount of [$100, 000,] you will need to provide evidence of good health that is satisfactory to the Company before the excess benefit can become effective. The guaranteed issue amount may increase as it is subject to the final level of participation in this plan. Monthly costs, based on your age, are shown below.*

[Employee Life Amounts*	Monthly Cost*	Employee Life Amounts*	Monthly Cost*
$10,000	$0.50	$60,000	$3.00
$30,000	$1.50	$80,000	$4.00
$50,000	$2.50	$100,000	$5.00**]**

To determine the cost for Supplemental Life coverage in excess of [$100,000], add the cost of insurance for [$100,000] to the amount over [$100,000] that you wish to elect. For example, to calculate the cost for [$150,000], add the monthly cost for [$100,000] of coverage to the monthly cost for [$50,000] of coverage.]

☐ I **elect** to enroll in the Supplemental Life Insurance plan for $_____ at a monthly cost of $_____.
Employee Life Amount*

☐ I **decline** to enroll in the Supplemental Life Insurance plan.

[***NOTE**: Benefit reductions begin at age [65.] If you are or over age [65], the monthly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown. Please see your benefits administrator for further information.] **]**

[Supplemental Life Insurance – Spouse

If you elect the Supplemental Life Insurance plan for yourself, you may elect Supplemental Life Insurance coverage for your Spouse. Your election may be made in increments of [$5,000] to a maximum of [$50,000] but may not exceed 50% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of [$25,000], your spouse will need to provide evidence of good health that is satisfactory to the Company before the excess benefit can become effective. Use the rate chart and calculation line below to determine your Monthly cost for this coverage. Supplemental Spouse rates and premiums are based on the [employee's age, not the Spouse's age.]

[Spouse Life Amounts*	Monthly Cost*	Spouse Life Amounts*	Monthly Cost*
$5,000	$0.25	$30,000	$1.50
$15,000	$0.75	$40,000	$2.00
$25,000	$1.25	$50,000	$2.50**]**

☐ I **elect** to enroll in the Supplemental Life Insurance plan for $ _____ at a monthly cost of $ _____.*
Spouse Life Amount

☐ I **decline** to enroll in the Supplemental Life Insurance plan for my Spouse.

*Your cost may change if your age category changes during the benefit plan year.

SPOUSE

First Name	Last Name	Gender	Date of Marriage	Date of Birth	Benefit Amount

]

[Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life Insurance plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) from [date of birth] to [19] years ([23] years if a full time student). You may elect in increments of [$500] to a maximum of [$25,000] but you may not exceed [50%] of your approved election. Use the calculation line to determine your monthly cost for this coverage.

[Child Life Insurance Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Cost per Child	$0.10	$0.20	$0.30	$0.40	$0.50**]**

☐ I **elect** to enroll my dependent child(ren) in the Supplemental Life plan for $ _____ at the monthly cost below.

# of Children	X	Cost Per Child Above	=	$ Your Monthly Cost
_____		_____		_____

☐ I **decline** to enroll in the Supplemental Life Insurance plan for my dependent child(ren).

CHILD(REN):

First Name	**Last Name**	**Gender**	**Date of Birth**	**Benefit Amount**

]

[BENEFICIARY INFORMATION

Beneficiary Designation

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and [contingent] beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship to you, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:	[Contingent]:
● Mary J. Doe, Wife (not Mrs. John Doe).	● Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares 50%). ● Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
[Contingent]						**]**

[The beneficiary for life insurance on the lives of your spouse and/or children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon your written request.)

Beneficiary - Print full name & relationship to you
Name _____ Relationship _____

The Proposed Insured will be the beneficiary for any Dependent Coverage desired. **]**

HEALTH INFORMATION

Health Questions

For all "YES" answers check Yes. For all "NO" answers check No.

[PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:]

[If you are under age 75 please answer **all** of the following questions. **If you are age 75 or over, please answer** [all question(s)/questions marked [A1, B2, C1, D2, E1 thru E5]]]

[A1. [Has anyone proposed for coverage] been actively engaged in the full-time duties of [his/her/your] occupation during the [90 day] period immediately before the date of this [application]? [You: ☐ Yes ☐ No] [Spouse: ☐ Yes ☐ No] **]**

[A2. At any time during the past [12 months], [has anyone proposed for coverage] smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? [You: ☐Yes ☐ No] [Spouse: ☐ Yes ☐ No] **]**

[To the best of the [Applicant's] knowledge and belief during the past [10 years] has any of the [Applicants] at any time been treated or consulted a physician for or told they have a problem with any of the following:	**YES**	**NO**
B1. [Abnormal pulse		
B2. Alcoholism		
B3. Anemia or other blood conditions		
B4. Anxiety		
B5. Any disease or disorder of the brain or nervous system		
B6. Any disease or disorder of the digestive system		
B7. Any disease or disorder of the glands		
B8. Any disease or disorder of the heart, blood or circulatory system		
B9. Any disease or disorder of the lungs or respiratory system		
B10. Any disease or disorder of the skin, bones, or joints, including neck or back disorders		
B11. Arthritis		
B12. Asthma		
B13. Blood or circulatory or vascular conditions		
B14. Blood or sugar in urine		
B15. Bronchitis		
B16. Cancer		
B17. Chest pain		
B18. Colitis		
B19. Diabetes		
B20. Dizziness		
B22. Drug or alcohol or nicotine use on a regular basis - Indicate amount used daily		

(Continued from previous page)		
	YES	NO
B23 Eating disorder		
B24. Elevated cholesterol		
B25. Enlarged lymph nodes or glands		
B26 Epilepsy		
B27. Eyes, ears, nose or throat – chronic		
B28. Gallbladder		
B29. Genital or reproductive organ problems		
B30. Heart condition		
B31. Heart murmur		
B32. Hepatitis		
B33. High blood pressure		
B34. Immune system - except HIV		
B35. Impaired sight or hearing		
B36. Insulin dependent diabetes		
B37. Intestines		
B38. Kidney disease		
B39. Kidneys, bladder, or urinary tract – chronic		
B40. Leukemia		
B41. Liver		
B42. Mental or Nervous disorders, including depression		
B43. Paralysis		
B44. Pneumonia		
B45. Psychiatric		
B46. Rectum		
B47. Recurrent or chronic sleep disorders/apnea		
B48. Respiratory problems		
B49. Rheumatism		
B50. Severe headaches		
B51. Shortness of breath		
B52. Skin disorders, moles, melanoma, basal cell carcinoma		
B53. Spleen		
B54. Stomach		
B55. Stroke		
B56. Thyroid		
B57. Tuberculosis		
B58. Tumor		
B59. Ulcer		
B60. Upper or lower digestive system **]**		
[C1. To the best of the [Applicant's] knowledge and belief, [Has anyone proposed for coverage] ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder except for HIV?**]**		
[C2. To the best of the [Applicant's] knowledge and belief, during the past [5 years] [has anyone proposed for coverage] consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this [application]; or been confined or treated in any hospital, sanatorium or similar institution? **]**		

[ADDITIONAL QUESTIONS:	YES	NO
To the best of the [Applicant's] knowledge and belief, during the past [10 years] [has anyone proposed for coverage]:		
[D1. Had surgery or been told to have surgery?]		
[D2. Been in a hospital or other institution for diagnosis or treatment?]		
[D3. Had any injuries from a car accident, or filed a Worker's Compensation claim?]		
[D4. Been declined for any life or disability insurance coverage?]		
[D5. Consulted or been examined by any healthcare provider for anything other than normal physical exams or acute illness such as cold, flu or sore throat?]		
[D6. Had any lab tests, x-ray, electrocardiogram or other diagnostic testing other than those requested as part of routine physical with normal findings?]]		

[E1. To the best of the [Applicant's] knowledge and belief, during the past [2 years] [has anyone proposed for coverage] been hospitalized for any condition?]		
[E2. To the best of the [Applicant's] knowledge and belief, [has anyone proposed for coverage] been confined in a hospital, nursing home, sanatorium or similar institution due to illness in the past [6 months?]]		
[E3. To the best of the [Applicant's] knowledge and belief, [is anyone proposed for coverage] **currently** pregnant? [If yes, Name: _____ When is the baby due? _____ Are there any medical complications? _____ What was your pre-pregnancy weight?]_____]		
[E4. [To the best of the [Applicant's] knowledge and belief, [is anyone proposed for coverage] taking medication for any condition or disease?]		
[E5. To the best of the [Applicant's] knowledge and belief, are there any symptoms, injury, birth defect, congenital defect, disease or other disorder not mentioned above? Please list all.]		

(All Inclusive Additional Information)

If you answered "Yes" to any of the above questions, please explain the details. An additional sheet of paper may be used, if necessary.

Question Number	Name	Disorder or Reason	Dates To/From	Give details for any "Yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery.

(Individual Additional Information — May Follow Each Question)

[Applicant] name(s):	Question Number	Medical condition:	Date treatment started: Date admitted: Date discharged:
Treatment/Medication:	Date of last treatment:		Current Status:
Physicians name and complete address:			
Please provide Primary Care Physician's name and complete mailing address:			
			]

[Simplified Medical Underwriting Questions

During the past [5 years] have you been treated, diagnosed or received medical advice for a heart attack, stroke, cancer, back, muscle, joint or mental nervous disorders or Acquired Immune Deficiency Syndrome (AIDS)?

[Applicant] ☐ Yes ☐ No [Spouse ☐ Yes ☐ No] [Child ☐ Yes ☐ No]

Please review your answer to this question to be sure that you have answered it fully and truthfully. Answering "No" to this question will qualify you for coverage. Answering "Yes" to this question disqualifies you from automatic acceptance for coverage at this time. However, if you feel you have recovered or are no longer requiring medical services, you may ask for reconsideration by completing [an Application.] Please contact [your Human Resources department for this form.] **]**

I have read this completed application and represent that to the best of my knowledge and belief all statements and answers herein are complete, true and correctly recorded. All statements made by, or by the authority of, the applicant for the issuance, reinstatement or renewal of any such policy or contract shall be deemed representations and not warranties.

I also understand that although any misrepresentation contained herein or relied upon by the company will not render the contract void, such misrepresentation may be used to contest the validity of the coverage in a court of law, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by the Company for plan administration purposes to decide if the person(s) is/are eligible for coverage.

Subject to the deferred effective date provision I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an [application] and pay the first premium.

I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

[[Applicant] Confirmation

I have been given the opportunity to enroll in [ABC Company's LTD Group plan effective June 1, 2002]. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the Company and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages [on a post-tax basis.] I am not now disabled and I am performing all the duties of my occupation on a full-time basis. [My spouse is either actively at work or, if not employed, able to carry on all the normal and customary activities of a person of like age and sex in good health.]

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force. **]**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Please print [Applicant] Full Name (First and Last):			**[Please print Spouse's Full Name (First and Last)]**	
[APPLICANT'S] SIGNATURE (**required**) or Legal representative to [Applicant]	DATE SIGNED Relationship:	[OR	SPOUSE'S SIGNATURE (required only if applying for coverage)	DATE SIGNED**]**

[AUTHORIZATION

I authorize any doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer, consumer reporting agency; Medical Information Bureau, Inc.; or employer, to give the Company or its legal representative information about me. This includes information about my physical or mental health (including history, condition, diagnosis and treatment) except for drug and/or alcohol treatment records; other insurance coverage or employment status. The Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the Policy. This information will be treated as confidential.

Information regarding your insurability will be treated as confidential. We will not procure or cause to be prepared any investigative consumer report on your insurability. We or our reinsurers may, however, make a brief report to the Medical Information Bureau based strictly on information on the application and/or the enrollment form. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense of created by those who would conceal facts relevant to their insurability. If you apply to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon request will furnish that company with information about you from its files. We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Upon request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the bureau's files, you may seek correction from the Bureau. The address of the Bureau's information office is: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 telephone number 781-751-6000.]

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the effective date of my coverage. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request. **]**

[PRE-EXISTING CONDITIONS LIMITATION
(For Disability Income Coverage only)

I further understand that any condition that is excluded or limited by the policy will not be covered under this policy at any time. I understand that such excluded conditions are: any injury or sickness, diagnosed or undiagnosed, for which medical advice was given or treatment was recommended by or received from a physician, within six months before the effective date of my coverage.**]**

SERFF Tracking Number:	*AMAL-126774572*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*46529*
Company Tracking Number:	*ALTLP-05*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Life*		
Project Name/Number:	*Group Term Life Policy/ALTLP-05*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

This is the Flesch certification.

Attachment:

Flesch certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Claim form, etc.

Comments:

Attachments:

AMADB-AD-PLUS-01-FW-CLAIM FORM.pdf
AMADBDIS2-PLUS-01-GENERIC ILLUSTRATION.pdf
AMADBDIS-PLUS-01-DISCLOSURE.pdf

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue
White Plains, NY 10604

CERTIFICATION

Amalgamated Life Insurance Company has reviewed the enclosed forms(s) and certifies that to the best of its knowledge and belief, the form(s) meet(s) the minimum flesch scale readability requirements of your State.

FORM	**SCORE**
ALTLP-AR-05	46.4
ALTLC-AR-05	48.3
ALTLRDBEC-AR-05	47.7
ALTLCCRC-AR-05	49.2
ALTLADDSBRC-AR-05	48.4
ALTLADDRepRC-AR-05	46.1
ALTLADDRC-AR-05	55.0
ALTLABRC-AR-05	46.4
ALTLWPRC-AR-05	45.5
ALLIDIA-AR-10	45.8
ALLIDIE-AR-10	47.4
ALLIDIEOI-AR-10	45.2

Date: August 18, 2010

By: _____
Robert McCready
Assistant Vice President

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Ave., White Plains, NY 10604
Accelerated Benefit Claim Form

All Requested Information Must Be Provided

Transmittal Date_____

Section I	**To Be Completed by Member/Employee or Legal Representative**			
Insured's Name	Address			Amount of Accelerated Benefit
Social Security No.	Telephone No.	Date of Birth	Sex M F	Remaining Death Benefit
Occupation		Date Condition was First Identified		
Condition Contributing to Your Need for Accelerated Benefits		What Important Daily Duties Are You Unable to Perform?		
When Do You Expect to Resume The Majority of Your Duties?				
If You Are Currently In A Location Other Than Your Home, Please Provide Complete Name and Address:				
Type of Place (Relative's Home, Hospital, Nursing Home, etc.)		Telephone No.		
Section II	**To Be Completed by Employer**			
Employer/Group Name				
Address				
Insured's Annual Basic Earnings	Amount of Insurance	Date Employed		
Is Insured Still Working?		If Not, Date Last Worked		
If Insured Was Terminated, Please Specify Reason For Termination: Illness Retired Resigned Other				

Section III	Disclosures and Authorizations

1. Receipt of Accelerated Benefits may effect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for Accelerated Benefits, the Insured or their Authorized Representative should consult with the appropriate social services agency concerning how receipt will affect eligibility of the recipient and/or their spouse or dependents.
2. Receipt of Accelerated Benefits may be taxable. Prior to applying for such benefits the Insured should seek assistance from a qualified tax advisor.
3. This request for Accelerated Benefits is voluntary and without coercion on the part of any third party.
4. No healthcare facility as defined in Section 20 of the Public Health Law can require the Insured to accelerate payment of death benefits as a condition of admission or for providing care in any such facility.
5. The Remaining Death Benefit available to the Insured is set forth in Section I of this claim form. The Company will issue an amended schedule page to the Insured that will reflect the reduced face amount of death benefit available after payment of the Accelerated Benefit.
6. The company is prohibited from paying an Accelerated Benefit for a period of 14 days from the date on which the information under Section 41.4(e) of Regulation 143 is transmitted to the Insured.
7. This Claim Form must be completed and signed by the Insured not more than 30 days after the Transmittal Date on page 1 of this form.
8. The Company will provide, pursuant to Section 41.4(e) of Regulation 143, within 5 days after receipt of this form, a numerical computation of the effect on the Insured's death benefit with and without payment of an Accelerated Benefit and other related information.
9. The Insured acknowledges the Administrative Charge of [$75] will reduce the amount of any Accelerated Benefit paid.

I hereby authorize any hospital, healthcare facility, physician, surgeon or other healthcare professional to provide its agents or employees, or independent administrators acting on its behalf, information pertaining to any examination or treatment furnished to the above named patient or for any illness, injury or any condition the patient has had at any time in the past or may continue to have in the future up to the expiration of this authorization. I understand this information is collected in connection with claims for insurance benefits and to determine eligibility for benefits. This authorization is valid for the term of coverage of the policy. A photocopy of this authorization is as valid as the original. The Insured or the authorized Representative is entitled to receive a copy of this form.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Insured's Signature or
Legal Representative's Signature

_____

Date

_____

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, NY 10604

GENERIC ILLUSTRATION OF BENEFIT UNDER ACCELERATED BENEFIT RIDER

Insured	JOHN DOE
Certificate Number	1234
Group Policy Number	6789
Death Benefit	$5,000
Accelerated Benefit Available Under Rider:	[50%] of Death Benefit

Qualifying Events for Payment of Accelerated Benefit: When the Insured has a terminal condition (or a covered critical illness or is in a covered hospital confinement) as defined in the rider attached to the Insured's certificate of insurance

Accelerated Benefit Payable with Benefit Acceleration

1.	Amount of Accelerated Benefit	$2,500
2.	Administrative Charge	$ 75
3.	Amount Payable in Cash	$2,425
4.	Remaining Death Benefit	$2,500

Death Benefit Payable without Benefit Acceleration

$5,000

Date: 2/2/2007 By: Jean Jones

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, NY 10604

DISCLOSURE REGARDING ACCELERATED BENEFIT OPTION
(Required under Section 41.4(e) of Regulation 143.)

Insured_____

Certificate Number_____

Group Policy Number_____

Date of Request for Accelerated Benefit_____

Death Benefit_____

Accelerated Benefit Payable with Benefit Acceleration

1. Amount of Accelerated Benefit – [50%] of Death Benefit $ _____

2. Administrative Charge $ _____

3. Amount Payable for Accelerated Benefit $ _____

4. Remaining Death Benefit $ _____

Death Benefit Payable without Benefit Acceleration

$ _____

Date _____ By_____